



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

DR. STEPHEN E. EARLE

Respondent Name

EMPLOYERS INSURANCE CO OF WAUSAU

MFDR Tracking Number

M4-14-3218-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

JUNE 23, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Code 22551 was denied on the basis that 'Per NCCI, the procedure code is denied. Procedure included in 63081.' Per the NCCI Edits Table, code 22551, is NOT considered inclusive with code 63081.

Code 20937 was denied on the basis that 'primary code not billed.' The primary code to 20937 is code 22551, which was billed but not paid for.

Codes 22554 and 22585 were denied on the basis that 'this is a bundled procedure.' This is true, 22554 and 22845 are considered bundled with 22830. However, code 22830 was not paid either. At least one code must be paid for the bundling principle to apply.

Code 20937 was denied on the basis that 'this is a bundled procedure.' Per the NCCI Edits, this is incorrect. Code 20937 is not bundled with any procedure code reported.

Code 20926 was denied on the basis of 'no preauthorization.' Code 20926 is integral to procedure code 22830; therefore no preauthorization is needed as the code is common understood to be integral.

Code 22830 was denied on the basis that 'the procedure/service was not documented.' Please see the attached operative report for the descriptive detail of the procedure."

Amount in Dispute: \$13,490.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 21, 2014	CPT Code 22551 Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy and decompression of spinal cord and/or nerve roots; cervical below C2	\$5,040.00	\$0.00
	CPT Code 20937 Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or	\$500.00	\$0.00

	fascial incision) (List separately in addition to code for primary procedure)		
February 21, 2014	CPT Code 22554 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2	\$2,500.00	\$0.00
	CPT Code 22585 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)	\$700.00	\$0.00
	CPT Code 22845 Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)	\$2,000.00	\$0.00
	CPT Code 20930 Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)	\$500.00	\$0.00
	CPT Code 20926 Tissue grafts, other (eg, paratenon, fat, dermis)	\$750.00	\$414.70
	CPT Code 22830-59 Exploration of spinal fusion	\$1,500.00	\$0.00
TOTAL		\$13,490.00	\$414.70

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.308 sets out the procedures for resolving a medical necessity/preauthorization dispute.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - MX59-Per NCCI, the procedure code is denied, as included in a more extensive procedure. Procedure included in 63081.
 - MX59-Per NCCI, the procedure code is denied, as included in a more extensive procedure. Procedure included in 22551.
 - U058-Procedure code should not be billed without appropriate primary procedure.
 - B291-This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed.
 - X170-Pre-authorization was required, but not requested for this service per DWC rule 134.600.
 - X901-Documentation does not support level of service billed.
 - X193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
5. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on July 1, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

1. Is the allowance of CPT code 22551 included in the allowance of another service/procedure billed on the disputed date of service?
2. Is the requestor entitled to reimbursement for CPT code 20937?
3. Is the allowance of CPT code 22554 included in the allowance of another service/procedure billed on the disputed date of service?
4. Is the allowance of CPT code 22585 included in the allowance of another service/procedure billed on the disputed date of service?
5. Is the allowance of CPT code 22845 included in the allowance of another service/procedure billed on the disputed date of service?
6. Is the allowance of CPT code 20930 included in the allowance of another service/procedure billed on the disputed date of service?
7. Was CPT code 20926 preauthorized?
8. Does the documentation support billing CPT code 22830-59?

Findings

1. According to the explanation of the respondent denied reimbursement for CPT code 22551 based upon reason code "MX59."

On the disputed date of service, the requestor billed codes 22551, 20937, 22326-59, 22554, 22585, 22851-59, 22845, 63081, 63082, 20930, 20926, 22855-22, and 22830-59.

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

28 Texas Administrative Code §134.203(b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

Per CCI edits, CPT code 22551 is a component of 63081; however, a modifier is allowed to differentiate the service. A review of the submitted medical bill finds that the requestor did not append a modifier to code 22551; therefore, the respondent's denial based upon reason code "MX59" is supported.

2. According to the explanation of the respondent denied reimbursement for CPT code 20937 based upon reason code "U058."

The requestor contends that "Code 20937 was denied on the basis that 'primary code not billed.' The primary code to 20937 is code 22551, which was billed but not paid for."

Code 20937 is an "add-on" code that describes additional services related to code 22551. Because the requestor did not support billing the primary code 22551 as stated above in number 1, the 'add-on' code is also not supported.

3. According to the explanation of the respondent denied reimbursement for CPT code 22554 based upon reason code "B291".

Per CCI edits, CPT code 22554 is a component of 22551; however, a modifier is allowed to differentiate the service. A review of the submitted medical bill finds that the requestor did not append a modifier to code 22554; therefore, the respondent's denial based upon reason code "B291" is supported.

4. According to the explanation of the respondent denied reimbursement for CPT code 22585 based upon reason code "B291".

Per CCI edits, CPT code 22585 is a component of 22551; however, a modifier is allowed to differentiate the service. A review of the submitted medical bill finds that the requestor did not append a modifier to code 22585; therefore, the respondent's denial based upon reason code "B291" is supported.

5. According to the explanation of the respondent denied reimbursement for CPT code 22845 based upon reason code "B291".

Per CCI edits, CPT code 22845 is a component of 22855; however, a modifier is allowed to differentiate the service. A review of the submitted medical bill finds that the requestor did not append a modifier to code

22845; therefore, the respondent's denial based upon reason code "B291" is supported.

6. According to the explanation of the respondent denied reimbursement for CPT code 20930 based upon reason code "B291".

Code 20930 is an "add-on" code that describes additional services related to code 22551. Because the requestor did not support billing the primary code 22551 as stated above in number 1, the 'add-on' code is also not supported. In addition, per CMS guidelines, code 20930 is a status "B-Bundled" code; therefore, it is a packaged service. As a result, separate reimbursement is not recommended.

7. The respondent denied reimbursement for code 20926 based upon a lack of preauthorization.

The requestor contends that "Code 20926 was denied on the basis of 'no preauthorization.' Code 20926 is integral to procedure code 22830; therefore no preauthorization is needed as the code is common understood to be integral." Per CCI edits code 20926 is not integral to procedure code 22830.

In accordance with 28 Texas Administrative Code §133.308, the requestor disputed the respondent's denial of preauthorization for "hardware removal at C4, C5, C6 and C3-C4 ACDF/AISF with a one day length of stay." The Independent Review Organization, MedHealth Review, Inc. found that the previous adverse determination should be overturned. The Division finds that a preauthorization issue does not exist and reimbursement is recommended.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2014 DWC conversion factor for this service is 69.98.

The Medicare Conversion Factor is 35.8228

Review of Box 32 on the CMS-1500 the services were rendered in zip code 78233, which is located in Live Oak; therefore, the Medicare participating amount is based on locality "Rest of Texas".

The Medicare participating amount for code 20926 is \$424.57.

Using the above formula, the MAR is \$829.40; however, this code is subject to multiple procedure rule discounting = \$414.70. This amount is recommended for additional reimbursement.

8. According to the submitted explanation of benefits, the respondent denied reimbursement for code 22830-59 based upon reason code "X901." A review of the Table of Disputed Services finds that the requestor listed code 22830-50 not 22830-59. Based upon the submitted medical bills and explanation of benefits, the respondent did not audit code 22830-50; therefore, it is not eligible for medical fee dispute resolution.

Per CCI edits, CPT code 22830 is a component of code 22554; however, a modifier is allowed to differentiate the service. The requestor appended modifier "59-Distinct Procedural Service" to code 22830.

Modifier 59 is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59.

Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.”

The requestor’s documentation does not support “a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.” As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$414.70.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$414.70 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	03/13/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.